

The Equitable Healthcare Survey II:

PHYSICIANS' ATTITUDES TOWARD COST CONTAINMENT

Conducted for
The Equitable Life Assurance Society of the United States

March 1984

Project Directors :

Humphrey Taylor, President, Louis Harris and Associates, Inc.
Asha Paranjpe, Ph.D., Research Director

CONTENTS

	Page
INTRODUCTION	1
Survey Content	1
A Note on the Tables	1
Acknowledgements	1
SURVEY HIGHLIGHTS	2
CHAPTER 1:	
GENERAL ATTITUDES TOWARD THE	
HEALTH CARE SYSTEM	6
Overall View of the Health Care System	6
Suggested Changes for the Health Care System ..	8
Satisfaction and Dissatisfaction with Health Care	10
CHAPTER 2:	
REASONS FOR INCREASED	
SPENDING ON HEALTH CARE	13
CHAPTER 3:	
REACTIONS TO PROPOSED	
COST-CONTAINMENT	
CHANGES IN HEALTH CARE	
SERVICES AND COVERAGE	22
Introduction	22
The Findings	22
CHAPTER 4:	
OPINIONS ON COST-SHIFTING AND	
HEALTH CARE COVERAGE FOR	
THE UNEMPLOYED	42
APPENDIX A:	
SURVEY METHOD	45
The Sample	45
Interviewing	45
Data Processing	45
Weighting of the Data	45
APPENDIX B:	
PROFILE OF THE PHYSICIAN SAMPLE	46

TABLES

CHAPTER 1: GENERAL ATTITUDES TOWARD THE HEALTH CARE SYSTEM

1-1	
OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: PHYSICIANS BY AMA MEMBERSHIP, REGION, AND YEARS SINCE GRADUATION.....	6
1-2	
OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	7
1-3	
PRIORITY FOR CHANGES IN THE U.S. HEALTH CARE SYSTEM: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	8
1-4	
SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	11
1-5	
ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	12

CHAPTER 2: REASONS FOR INCREASED SPENDING ON HEALTH CARE

2-1	
MAIN REASON FOR INCREASED SPENDING ON HEALTH CARE SERVICES: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	13
2-2	
SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	14

2-3	
HOW MUCH "LACK OF COMPETITIVE PRICING AMONG DOCTORS, HOSPITALS, OR NURSING HOMES" HAS CONTRIBUTED TO INCREASED HEALTH CARE SPENDING: BY AMA MEMBERSHIP AND YEARS SINCE GRADUATION.....	17
2-4	
UNDERLYING CAUSES OF THE INCREASE IN HEALTH CARE SPENDING: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	19
2-5	
ESTIMATES BY PHYSICIANS OF THE PERCENTAGE OF HEALTH CARE COSTS INCURRED BY THE HIGHEST SPENDING 10% OF THE POPULATION.....	20
2-6	
REASONS GIVEN BY PHYSICIANS FOR THE INCREASED CONCENTRATION OF HEALTH CARE SPENDING.....	21

CHAPTER 3: REACTIONS TO PROPOSED COST-CONTAINMENT CHANGES IN HEALTH CARE SERVICES AND COVERAGE

3-1	
ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS: BY PHYSICIANS.....	25
3-2	
ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED.....	31

3-3

ACCEPTABILITY OF POLICIES WHICH HAVE A
DIRECT OR INDIRECT IMPACT ON PHYSICIANS'
INCOMES: BY REGION AND YEARS SINCE GRAD-
UATION 38

3-4

ACCEPTABILITY OF PROPOSED CHANGES IN
HEALTH CARE COVERAGE DESIGNED TO
REDUCE NONESSENTIAL UTILIZATION BY SHIFT-
ING MORE OUT-OF-POCKET COST TO THE
AMERICAN PUBLIC: PHYSICIANS BY YEARS
SINCE GRADUATION 39

3-5

TRADE-OFFS IN HEALTH CARE COVERAGE CON-
SIDERED FAIR AND REASONABLE: PHYSICIANS,
PUBLIC, AND OTHER GROUPS COMPARED 41

**CHAPTER 4: OPINIONS ON COST-SHIFTING
AND HEALTH CARE COVERAGE FOR THE
UNEMPLOYED****4-1**

ATTITUDES TOWARD MEDICARE AND MEDICAID
COST-SHIFTING: PHYSICIANS, PUBLIC, AND
OTHER GROUPS COMPARED 42

4-2

PHYSICIANS' ATTITUDES TOWARD HEALTH
CARE COVERAGE FOR THE UNEMPLOYED 43

4-3

ATTITUDES TOWARD HEALTH CARE COVERAGE
FOR THE UNEMPLOYED DESPITE COST TO
OTHERS: PHYSICIANS, PUBLIC, AND OTHER
GROUPS COMPARED 44

APPENDIX B

PROFILE OF THE PHYSICIAN SAMPLE 46

INTRODUCTION

This survey was designed to provide a detailed assessment of the attitudes of American physicians on the subject of health care costs and cost-containment policies. It is based on 500 interviews conducted in January and February 1984 with a representative cross section of physicians.

In the summer of 1983, Louis Harris and Associates conducted a major study, **The Equitable Health-care Survey: Options for Controlling Costs**, for The Equitable Life Assurance Society of the United States. That study provided a detailed assessment of the attitudes of the American public, employers, unions, hospital administrators, the health insurance industry, and physicians who head state and local medical societies (referred to as "physician leaders") on the subject of health care costs and cost-containment policies. The findings of that study were publicly released in October 1983. The present survey was designed to complement that study by examining the views of a national cross section of practicing physicians on the same subject.

The questionnaire used in this study was virtually identical to the one used in the earlier study. Therefore, it is possible to compare the views of the physicians surveyed here with those of physician leaders, hospital administrators, and the American public, all surveyed earlier. While the focus of this report is the survey of physicians, important comparisons with the groups interviewed in the earlier study are included.

Survey Content

Topics explored in the survey are outlined below:

- General attitudes toward the health care system in the U.S. and the system's particular strengths and weaknesses;
- Perceptions of the reasons for health care cost escalation and possible solutions;
- Attitudes toward a broad range of cost-containment policies and programs in terms of their anticipated effectiveness and acceptability; and

- Attitudes toward various proposed trade-offs between better coverage on the one hand and greater cost to the patient on the other hand.

The content of the survey reflects an interest in not only providing an analysis of the problems of health care costs but also in providing information on attitudes toward various proposed solutions to those problems.

A Note on the Tables

Percentages in the tables may not add to 100% because of rounding or the acceptance of multiple responses. And, where indicated, percentages in some tables add up to less than 100% because of the exclusion of "not sure" responses. All tables show unweighted percentages for the professional groups and weighted percentages for the public sample, and they indicate the unweighted bases in each group.

Acknowledgements

Louis Harris and Associates is deeply grateful to The Equitable Life Assurance Society of the United States for making this research possible. The contribution of the following individuals at Equitable is also gratefully acknowledged: Richard Freiburger, James T. Glynn, Allison Cooke Kellogg, Arthur Lifson, Frederick J. Malley, Jr., and Robert McFarlin. Each of these individuals made substantive contributions to the study design and questionnaire development.

Final responsibility for the survey design and the findings and conclusions contained in this report rests with Louis Harris and Associates.

SURVEY HIGHLIGHTS

This summary provides an overview of the opinions of physicians on issues explored in this survey. Where pertinent, comparisons are made with the findings of the earlier survey.* Interested readers are urged to examine the full report for comparisons between the opinions of physicians surveyed in this study and those of physician leaders, hospital administrators, and the American public, surveyed earlier on all the major issues.

1. Less than half of all physicians believe that the American health care system works well and needs only minor changes.

This finding contrasts sharply with the views of physicians who head state, local, and specialty medical societies (physician leaders), two-thirds of whom believe that the nation's health care system works well.

These responses are strikingly different from those of the American people, only 21% of whom believed, in 1983, that the health care system was working pretty well, and most of whom felt that fundamental changes were needed or that the system needed to be completely rebuilt.

These differences reflect the gulf that exists between physicians' attitudes and public opinion on the subject of health care costs and on the need for action to contain them.

2. There is no consensus among physicians with regard to priorities for change in the nation's health care system.

The answers given most frequently in reply to a question concerning which one change they would most like to see relate to improved access to health care, cost containment, and less government interference and regulation of the health care system.

3. Most physicians are satisfied with the availability and quality of health care generally, with their own health insurance benefits, and with the cost of health care.

However, fully 41% of physicians are dissatisfied with the total cost of care, and 32% are dissatisfied with out-of-pocket costs.

4. A majority (59%) of physicians think that the cost of hospitalization is unreasonably high.

However, sizable majorities believe that the costs of doctors' visits, laboratory tests, and health insurance are reasonable. In contrast to the opinion of a majority of physician leaders who think the cost of prescription drugs is reasonable, physicians reveal only a plurality of opinion regarding this issue.

5. Majorities, in most cases large majorities, of physicians think that seven different factors have contributed significantly to the rise in health care spending over the last few years.

However, only a minority (17%) think that unit-cost inflation — the increasing cost of the same services — is the main reason. This latter view contrasts sharply with that of the American public, 44% of whom feel that unit-cost inflation is the main reason for increased spending.

The factors most widely believed by physicians to have had a major impact on health care spending are:

- The increasing use of expensive equipment and technology;
- The fact that the population as a whole is getting older;
- The growth of expensive malpractice suits and malpractice insurance;
- The increased availability of government-funded programs such as Medicare and Medicaid;
- The increased availability of employer-provided health insurance;
- Doctors ordering more laboratory tests than are necessary; and
- Unnecessary hospitalization.

*The Equitable Healthcare Survey: Options for Controlling Costs. Louis Harris and Associates, August 1983.

6. A majority of physicians believe that the third-party payment system, as it exists today, is a major contributor to increased health care spending.

While large majorities of physicians believe that the third-party payment system, the practice of defensive medicine, and the aging of the population have contributed to increased health care spending, there is a plurality of opinion on the idea that the increase is due to a lack of competitive pricing in the health care industry.

Younger physicians and physicians who are not members of AMA tend to agree that a lack of price competition contributes to health care cost inflation.

7. A majority of physicians believe that the present health care system is price competitive.

Physicians' views on this subject are in sharp contrast to those of hospital administrators and the public. A majority of the public (76%) believe that one of the problems of health care is that there is no competition to keep prices down. Furthermore, majorities of hospital administrators, insurance executives, corporate benefits officers, and union leaders all share the public's view that the nation does not have a price-competitive system.*

In this context, it is important to note that only 16% of the public have ever chosen a physician because his or her fees were lower than those of another doctor.*

8. There is no agreement among physicians as to the proportion of all health care costs that are incurred by the highest spending 10% of the population.

The median response is that 56% of all spending can be attributed to this 10% of the population, a figure somewhat lower than available data and other estimates would suggest.

Physicians believe that the main reasons for the increased concentration of health care spending on a small proportion of the public are: the aging of the population, the use of more expensive procedures to save or prolong life, the unhealthy lifestyles of some Americans, the use of new medical technology, and the overuse of health care services by a few people.

9. Reactions to specific health care cost-containment policies vary from almost unanimous acceptance to overwhelming opposition.

In general, there is a relatively high correlation between the perceived effectiveness of a policy and its acceptability. Where a policy is perceived to be effective, it is generally acceptable. Where it is not effective, it is generally not thought to be effective. However, there are a few important exceptions to this rule.

10. By large majorities, physicians believe that most policies which would increase cost-sharing by patients would be both effective and acceptable.

Specific policies endorsed by large numbers of physicians relate to increased deductibles and copayments, and requiring patients to pay a part of their employer-paid insurance premiums. On the other hand, less than half of the physicians view a new tax on the top portion of large health insurance premiums as an effective or acceptable cost-containment measure.

11. Overwhelming majorities of physicians endorse changes in the health care system that would reduce hospitalization.

Alternatives to hospitalization in the care of the chronically ill or for tests and minor surgery are considered both effective and acceptable in containing health care spending. However, certification by insurance companies prior to nonemergency hospitalization is acceptable to less than half of the physicians.

*The Equitable Healthcare Survey: Options for Controlling Costs. Louis Harris and Associates, August 1983.

- 12. Physicians view the proposal to require second opinions prior to nonemergency surgery as generally acceptable.**

However, there is some doubt about its effectiveness in controlling costs.

- 13. Discouraging the duplication of expensive equipment and specialists at nearby hospitals is a proposal acceptable to almost two-thirds of the physicians.**

Almost three-fourths of the group consider this an effective means for containing health care costs.

- 14. Utilization reviews are thought to be at least somewhat effective, but a sizable minority (44%) do not regard them as acceptable.**

- 15. The proposal to fix fees paid to doctors and hospitals based on diagnosis-related groups (DRG's) is unacceptable to a clear majority of physicians.**

However, over half of the physicians concede that it is an effective cost-containment strategy.

- 16. The notion of government price controls draws the greatest consensus of negative responses from physicians.**

Although almost half agree that such controls would reduce health care spending, fully 85% find the proposal unacceptable.

- 17. Health Maintenance Organizations (HMO's) and preferred provider plans are unacceptable to a majority of physicians.**

However, medical opinion is more receptive to a system where a primary care physician receives a predetermined fee for providing basic medical care and is also responsible for authorizing additional health care services.

- 18. Large majorities of physicians consider insurance plans that provide individual incentives for healthy living or group incentives for below target expenditures to be both effective and acceptable in controlling health care costs.**

- 19. Changes in laws relating to malpractice that would reduce the pressure on doctors to practice defensive medicine are generally thought to be both effective and acceptable.**

- 20. Most physicians believe that changing anti-trust laws so that third-party payers can join together to negotiate fees with providers would be an effective cost-containment strategy.**

A smaller majority consider this proposal acceptable.

- 21. Business coalitions formed to control health care costs are seen as both effective and acceptable by a majority of physicians.**

- 22. There is some resistance among physicians to encouraging the use of nurse practitioners, midwives, and physicians' assistants instead of physicians.**

While over 50% find this change unacceptable, a large minority (46%) also believe that this would not be an effective means for controlling costs.

- 23. While most physicians believe that reducing the use of so-called "heroic" medicine would be effective in controlling health care spending, a smaller majority find this proposal acceptable.**

- 24. There is overwhelming disapproval of the concept of cost-shifting.**

Policies that result in a shift in the cost of treatment for Medicare and Medicaid patients to fees paid by private-sector patients are looked upon with disfavor by most physicians.

25. Health care coverage for the unemployed is favored by most physicians, even if it means additional direct or indirect cost to other people.

While the majority of physicians favor providing this coverage by extending employer-paid insurance or by encouraging each state to finance it, they oppose financing this coverage through a federal program or from any type of new tax.

26. In general, physicians in the South are more conservative.

They are more satisfied with the status quo and are least likely to accept policies which would adversely affect their income.

27. In most instances, younger physicians (i.e., physicians who have graduated more recently) are more receptive to the proposed changes in the health care system than are older physicians.

The changes that older physicians endorse in larger numbers than younger physicians are those that would shift additional costs to the patient. AMA members, who tend to be older than nonmembers, also tend to be more conservative than nonmembers in accepting changes in the health care system that would place constraints on the price or use of health care services and on equipment purchases.

28. Physicians are out of step with the nation on many key issues.

They are less critical of the status quo, much more likely to believe that the health care system is price competitive, and much less willing to accept alternatives to the traditional fee-for-service, doctor-patient relationship than the public, hospital administrators, employers, union leaders, or insurance executives.*

29. However, practicing physicians are more likely to see the need for change than are their elected leaders.

They are also somewhat more willing to accept alternative delivery systems.

CHAPTER 1: GENERAL ATTITUDES TOWARD THE HEALTH CARE SYSTEM

Overall View of the Health Care System

Less than half of all physicians are satisfied with the nation's health care system. While 48% of all physicians surveyed believe that on the whole the American health care system works pretty well and that only minor changes to the system are needed, an equal number believe that fundamental changes are needed to make the health care system better. Very few physicians (3%) believe that there is so much wrong with the American health care system that it is necessary to completely rebuild it.

Whereas a majority (54%) of the physicians who are members of the American Medical Association (AMA) view the health care system as working pretty well, a majority (54%) of those who are not members of AMA view the system as needing fundamental changes to make it work better. The former view is also held by a clear majority of physicians in the South (55%) and those who graduated eleven to twenty years ago (55%). The latter view is held by a clear majority of physicians in the West (57%), and by smaller majorities of physicians who graduated less than six years ago (52%) or over twenty years ago (51%). There is a plurality of opinion on this issue among physicians in the East and Midwest, and among those who graduated six to ten years ago (Table 1-1).

Table 1-1

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: PHYSICIANS BY AMA MEMBERSHIP, REGION, AND YEARS SINCE GRADUATION

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Total Physicians	AMA Membership		Region				Years Since Graduation			
		Member	Non- member	East	Mid- west	South	West	5 or Less	6-10	11-20	21 or More
Base	500	266	232	150	112	128	110	73	120	119	175
	%	%	%	%	%	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	48	54	41	46	50	55	40	47	48	55	44
There are some good things in our health care system, but fundamental changes are needed to make it work better	48	43	54	48	47	41	57	52	47	42	51
The American health care system has so much wrong with it that we need to completely rebuild it	3	2	3	5	2	2	2	1	5	1	3
Not sure	1	1	1	1	1	1	—	—	1	1	1

Compared to the physicians surveyed in this study, physician leaders reveal a greater consensus of opinion, and believe that the system works pretty well (Table 1-2). On the other hand, the physicians' views contrast sharply with that of the American public, fully 25% of whom hold the view that the American health care system has so much wrong with it that we need to completely rebuild it. Only 21% of the American public feel that the system works pretty well, while 50% believe it needs fundamental changes to make it work better.

Table 1-2

**OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	48	68	41	21
There are some good things in our health care system, but fundamental changes are needed to make it work better	48	32	56	50
The American health care system has so much wrong with it that we need to completely rebuild it	3	—	2	25
Not sure	1	—	1	4

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

Suggested Changes for the Health Care System

There is a wide diversity of opinion among physicians regarding the single change they would most like to see in the health care system. A variety of changes related to better access to health care are given top priority by 20% of the physicians, while 14% cite a variety of changes related to cost containment, and 14% would like to see less government interference and regulation. Some would like to see more public education about medical matters (5%), more investigation of third-

party reimbursement (5%), and better regulation of malpractice suits (5%).

Physicians, in general, differ from physician leaders in that they give priority to access-related changes in greater numbers, and to public education regarding medical matters in smaller numbers, than do physician leaders (Table 1-3). They differ from both hospital administrators and the American public in giving priority to changes related to cost reduction in smaller numbers, and to a reduction in government interference and control in greater numbers, than do those two groups.

Table 1-3

PRIORITY FOR CHANGES IN THE U.S. HEALTH CARE SYSTEM: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

	Physicians	Physician Leaders [†]	Hospital Administrators [†]	Public [†]
Base	500	100	100	1501
	%	%	%	%
Cost-Reduction or Control (Total)	14	14	19	23
Control or limit costs	9	8	13	12
Lower hospital costs	2	2	—	5
Government should control health care/insurance costs	2	2	3	2
Reduce doctors' charges	1	2	3	4
Access-Related Changes (Total)	20	13	17	24
Assure availability of equal quality care for all	9	4	2	5
For those who can't afford it, cut costs/provide financial support	5	3	7	5
Need better insurance coverage; reevaluate coverage	5	6	8	3
More/better care for the elderly; more inclusive Medicare	1	—	—	11

(Continued)

Table 1-3 (Continued)

**PRIORITY FOR CHANGES IN THE U.S. HEALTH CARE SYSTEM:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Other Specific Changes				
Less government interference/ regulation	14	15	6	1
Public education regarding medical programs and costs	5	13	4	2
More investigation of third- party reimbursement	5	6	3	*
Better regulation of malprac- tice suits	5	2	—	—
People should pay more of the cost of health care	3	8	6	1
Socialize medicine, national health service	3	—	5	8
Medicare/Medicaid should pro- vide uniform reimbursement	3	—	2	1
Less impersonal doctor/patient relationship	2	6	3	3
More doctors	2	1	2	2
Encourage formation/use of HMO's	2	1	3	*
Better doctors: responsibility, proficiency, attitude	2	—	2	1
Better hospitals	2	1	—	2
Change fee for service to other form of payment	1	2	8	1
Preventive medicine should be implemented/augmented	1	3	2	2
Eliminate waste, fraud, graft, pilfering, handouts	1	—	4	2
Eliminate unnecessary use of facilities, Medicaid, Medicare	1	1	—	1
Need more clinics	1	—	—	1
Investigate/regulate insurance companies, assure policy is understood	*	—	—	1
All Other Reasons Mentioned (Total)	6	1	8	4
Not sure	8	5	2	18

*Less than 0.5%

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983

Satisfaction and Dissatisfaction with Health Care

Large majorities of physicians are satisfied with the availability and quality of health care and with their health insurance benefits, while a sizable minority express dissatisfaction with the various costs of health care. Fully 41% express some degree of dissatisfaction with the total cost of health care, and 32% are dissatisfied with the out-of-pocket cost of health care. Physician leaders and hospital administrators share these views in similar numbers. The majority of the American public, on the other hand, are dissatisfied with these costs, but are satisfied with the availability and quality of health care, as well as their health insurance benefits (Table 1-4).

Table 1-4

**SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. I will mention several different aspects of health care. Please say for each one whether—in the light of your own experience—you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied.

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1,501
	%	%	%	%
The quality of health care generally				
Very satisfied	62	84	58	30
Somewhat satisfied	30	16	34	47
Somewhat dissatisfied	5	—	5	14
Very dissatisfied	1	—	—	6
The availability of health care				
Very satisfied	51	60	49	39
Somewhat satisfied	36	33	37	36
Somewhat dissatisfied	10	7	7	16
Very dissatisfied	1	—	3	7
Your health insurance benefits				
Very satisfied	47	55	52	37
Somewhat satisfied	35	34	27	33
Somewhat dissatisfied	13	7	13	15
Very dissatisfied	3	4	6	10
The out-of-pocket cost of health care				
Very satisfied	22	26	30	16
Somewhat satisfied	40	41	37	26
Somewhat dissatisfied	25	25	22	26
Very dissatisfied	7	5	11	28
The total cost of health care, including what both you and your insurance pay				
Very satisfied	18	27	17	18
Somewhat satisfied	37	34	36	28
Somewhat dissatisfied	30	28	31	25
Very dissatisfied	11	11	15	25

Note: Those "not sure" or for whom item was "not applicable" are not shown on this table.

¹ Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

Physicians' attitudes towards the cost of specific health care services vary substantially. Seventy-four percent of physicians consider the cost of doctors' visits reasonable and 60% consider the cost of health insurance reasonable, while a smaller majority (55%) think that laboratory tests are reasonable. By contrast, a noteworthy majority (59%) of physicians view the cost of hospitalization as unreasonable. This view on hospitalization cost is shared by a majority (over 60%) of physician leaders and the American public, but only by a minority (40%) of hospital administrators.

Physicians' views are almost evenly divided on whether or not the cost of prescription drugs is reasonable. This stance differs significantly from that of physician leaders, 71% of whom consider prescription drugs as reasonable in cost.

In general, there is a lower consensus of opinion among physicians than among physician leaders regarding the cost of the various health care services (Table 1-5).

Table 1-5
ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. Do you think the cost of (READ EACH ITEM) is very reasonable, somewhat reasonable, somewhat unreasonable, or very unreasonable for what you get?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Doctors' visits				
Very reasonable	27	35	10	13
Somewhat reasonable	47	50	47	32
Somewhat unreasonable	17	12	34	29
Very unreasonable	2	—	7	22
Health insurance				
Very reasonable	12	17	17	20
Somewhat reasonable	48	55	49	31
Somewhat unreasonable	31	25	25	24
Very unreasonable	6	2	8	20
Laboratory tests and X-rays outside hospitals and clinics				
Very reasonable	17	26	8	9
Somewhat reasonable	38	48	45	24
Somewhat unreasonable	27	22	27	29
Very unreasonable	10	3	9	27
Prescription drugs				
Very reasonable	8	15	12	14
Somewhat reasonable	41	56	39	30
Somewhat unreasonable	38	21	36	28
Very unreasonable	8	6	10	26
Hospitalization				
Very reasonable	5	8	17	11
Somewhat reasonable	33	27	43	22
Somewhat unreasonable	40	51	25	27
Very unreasonable	19	12	15	26

Note: Those "not sure" or for whom item was "not applicable" are not shown on this table.

¹Source: The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983.

CHAPTER 2: REASONS FOR INCREASED SPENDING ON HEALTH CARE

Physicians, in contrast with physician leaders, hospital administrators, and the American public, display a fair degree of unanimity in their views regarding the principal reason for increased health care spending. While 59% of the physicians consider the use of expensive treatments and equipment as the main reason for increased spending, only 18% cite increased utilization, and 17% cite unit-cost inflation as the main reason.

Although both physician leaders and hospital administrators are most likely to view expensive treatment and equipment as the main reason for increased health care spending, a sizable number (31% and 29%, respectively) lay the blame on increased utilization. The American public, on the other hand, is most likely (44%) to view unit-cost inflation as the principal reason for the increased spending, followed by the use of expensive treatments and equipment (34%), and lastly, increased utilization (17%) (Table 2-1).

Table 2-1

MAIN REASON FOR INCREASED SPENDING ON HEALTH CARE SERVICES: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. The amount of money spent on health care services has been growing rapidly over the last fifteen years. Total national health care spending has gone from \$51 billion in 1967 to over \$300 billion last year. The increased amount of money spent on health care services is partly a result of *people using more health care services than they used to*, partly a result of *the use of new and more expensive treatments and equipment*, and partly a result of *the increasing cost of the same services*.

Which one of these three do you think is the main reason for the increased spending on health care services?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
The use of new and more expensive treatments and equipment	59	46	49	34
People using more health care services than they used to	18	31	29	17
The increasing cost of the same services	17	19	16	44
Not sure	6	3	4	4

¹Source: *The Equitable Healthcare Survey: Options for Controlling Costs*, Louis Harris and Associates, August 1983.

Table 2-2 indicates the extent to which each of ten specific practices is believed to have contributed to the rise in health care spending. The factors believed by over 75% of the physicians to have contributed to this rise in spending are:

- The increasing use of expensive new equipment and technology;
- The fact that the population as a whole is getting older;
- The growth of expensive malpractice suits;
- The increased availability of government-funded programs such as Medicare and Medicaid;
- The increased availability of employer-provided health insurance; and
- Doctors ordering more laboratory tests than are necessary.

A modest majority (56%) believe that patients being hospitalized for minor ailments has contributed to increased health care spending, while a marginal majority of physicians reject the notion that the rise in spending is due to the absence of competitive pricing or because people are staying in hospitals longer than is necessary.

Physicians' views on each factor appear to be slightly less defensive of their own profession than those of physician leaders. Physicians' views differ from those of hospital administrators and the American public in degree rather than direction on most factors. The most notable exception is the opinion of these groups on whether or not a lack of price competition among providers contributes to increased health care spending. While physicians marginally reject this notion, hospital administrators and the public endorse it by a wide margin.

Table 2-2

**SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. I will read you some reasons that are given for the rise in health care spending over the last few years. For each reason, please tell me if you think it has contributed very much, somewhat, not very much, or not at all to the increased health care spending in this country.

	Physicians	Physician Leaders [†]	Hospital Administrators [†]	Public [†]
Base	500	100	100	1501
	%	%	%	%
The increasing use of expensive new equipment and technology				
Very much	58	47	45	50
Somewhat	38	47	54	40
Not very much	3	5	1	6
Not at all	1	—	—	1
The fact that the population as a whole is getting older, and older people require more medical services				
Very much	53	65	52	32
Somewhat	40	34	39	45
Not very much	6	1	7	16
Not at all	1	—	2	5

Table 2-2 (Continued)

**SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
The growth of expensive malpractice suits which require doctors to pay for expensive malpractice insurance				
Very much	46	40	20	44
Somewhat	43	51	64	36
Not very much	10	9	15	12
Not at all	1	—	1	4
The increased availability of government-funded programs such as Medicare and Medicaid				
Very much	34	56	50	37
Somewhat	51	36	36	42
Not very much	11	8	10	13
Not at all	4	—	2	5
Doctors ordering more laboratory tests than are necessary				
Very much	28	11	26	46
Somewhat	56	58	54	34
Not very much	13	28	18	13
Not at all	2	2	2	4
The increased availability of health insurance provided by employers				
Very much	26	38	34	26
Somewhat	52	50	49	44
Not very much	18	11	14	19
Not at all	3	1	3	6
Patients being hospitalized for minor ailments that can be treated without hospitalization				
Very much	18	15	25	42
Somewhat	38	46	39	35
Not very much	35	32	31	16
Not at all	7	7	5	4
People staying in hospitals longer than necessary				
Very much	9	6	8	32
Somewhat	38	47	46	34
Not very much	42	43	42	24
Not at all	10	4	4	7

(Continued)

Table 2-2 (Continued)

**SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
The lack of competitive pricing among doctors, hospitals, or nursing homes				
Very much	8	4	29	44
Somewhat	39	33	39	33
Not very much	39	42	23	14
Not at all	11	17	8	5
Fraud and abuse by some nursing homes, doctors, and hospitals				
Very much	5	—	6	36
Somewhat	28	24	36	37
Not very much	53	67	51	17
Not at all	9	8	6	3

Note: Those who are "not sure" or responded "refused/no answer" are not shown on this table.

¹Less than 0.5%.

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

It should be noted that various subgroups of physicians hold slightly different views on whether or not a lack of competitive pricing among providers has led to the increase in health care spending. As is evident from Table 2-3, AMA members marginally reject the view that a lack of competitive pricing has resulted in increased health care spending, while non-AMA members marginally endorse it. The number of years since graduation appears to be related to opinion on this issue. A larger percentage (55%) of those who graduated recently (five years or less) endorse the idea that a lack of competitive pricing leads to increased spending, than of those who graduated twenty-one or more years ago (43%).

Table 2-3

**HOW MUCH "LACK OF COMPETITIVE PRICING AMONG DOCTORS, HOSPITALS, OR NURSING HOMES" HAS CONTRIBUTED TO INCREASED HEALTH CARE SPENDING:
BY AMA MEMBERSHIP AND YEARS SINCE GRADUATION**

	Total Physicians	AMA Membership		5 or Less	Years Since Graduation		
		Member	Non- member		6-10	11-20	21 or More
Base	500	266	232	73	120	119	175
	%	%	%	%	%	%	%
Very much	8	5	11	10	10	5	7
Somewhat	39	39	40	45	41	39	36
Not very much	39	40	38	37	33	45	38
Not at all	11	14	8	7	13	8	15
Not sure	3	3	3	1	3	2	5

The third-party payment system is viewed by the vast majority of physicians as contributing to increased health care spending. However, although they almost unanimously agree that patients over-utilize health care services when they themselves don't have to pay for those services, only a modest majority (55%) agree that doctors and hospitals will provide care without regard to cost if they know that insurance and not the patient is paying.

A significant minority (37%) of the physicians agree that spending has risen because there is no real competition to keep prices down. This view is held by only 27% of physician leaders, but by 55% of hospital administrators and 76% of the public (Table 2-4).

It appears that the majority of physicians (60%) and physician leaders (73%) believe that they are working within a price-competitive system, while the majority of their patients (76%) believe that they are not. It should be noted, however, that the public is not militantly demanding or encouraging a price-competitive system. Only 16% of the public (as reported in the earlier survey*) have ever chosen a physician because his or her fees were lower than those of another doctor.

*The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983

Table 2-4

**UNDERLYING CAUSES OF THE INCREASE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Now, I will read you some statements about some causes for the increase in health care spending and some possible solutions. Please tell me, for each one, if you agree with it or disagree with it.

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
If most patients don't have to pay for hospital care, they will want the best care available, no matter how expensive it is				
Agree	89	92	85	84
Disagree	10	8	15	15
Not sure	2	—	—	1
People would use fewer health care services if they personally had to pay a greater share of the cost				
Agree	94	96	92	78
Disagree	5	3	6	20
Not sure	1	1	2	1
One of the problems with health care is that there is no real competition to keep prices down				
Agree	37	27	55	76
Disagree	60	73	42	21
Not sure	3	—	3	2
If doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to cost				
Agree	55	53	63	74
Disagree	42	46	36	24
Not sure	3	1	1	2

Note: Those "not sure" or for whom item was "not applicable" are not shown on this table.

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

A great deal has been written about the concentration of health care spending that is attributable to a relatively small proportion of the population. This concentration reflects both the high cost of treating major medical cases and the heavy expenditure on patients in the last year of their lives. However, there is rather widespread disagreement among physicians as to the proportion of all health care costs that are incurred by the highest spending 10% of the population. The median response was that 56% of all spending can be attributed to this 10% of the population (Table 2-5).

The available evidence suggests that this is probably an underestimate. A study of the Federal Employee Benefit Program, conducted by the Congressional Budget Office in 1978, reported that 10% of the families covered accounted for 67% of total expenditures. The Health Care Financing Administration reported that in 1978, 8.8% of the elderly enrolled in Medicare accounted for 70.3% of Medicare expenditures. However, no comparable figure is available for the total population.

Table 2-5

ESTIMATES BY PHYSICIANS OF THE PERCENTAGE OF HEALTH CARE COSTS INCURRED BY THE HIGHEST SPENDING 10% OF THE POPULATION

- Q. It is clear that some people incur more health care costs than others. What percentage of all health care costs do you think is incurred by the 10% of the population who are the biggest consumers and who incur the highest costs?

	Total Physicians
Base	500
	%
Less than 30%	10
30%-39%	13
40%-49%	14
50%-59%	19
60%-75%	17
More than 75%	9
Not sure	17
Refused/no answer	1
Median percentage	56

As is evident from Table 2-6, physicians differ with respect to which factor contributes most to the increased concentration of health care spending. The two reasons cited by over one-fourth of the group are the aging of the population and the use of expensive procedures to save or prolong life. The use of new medical technology is mentioned by 12% of the physicians and unhealthy lifestyles is mentioned by 14%. Only 9% of the physicians believe that overutilization of health care services contributes to a concentration of spending.

Table 2-6

REASONS GIVEN BY PHYSICIANS FOR THE INCREASED CONCENTRATION OF HEALTH CARE SPENDING

- Q. The evidence is that the concentration of health care costs is growing. In other words, the 10% who incur the highest costs are consuming a higher and higher proportion of all costs. Which one of the following do you think contributes most to the increased concentration of health care spending?

	Total Physicians
Base	500
	%
Aging of the population	31
Use of expensive procedures to save or prolong life	27
New medical technology	12
Unhealthy lifestyles	14
Overuse and abuse of health care services by a few people	9
More insurance coverage	4
None of these (vol.)	1
Not sure	3

CHAPTER 3: REACTIONS TO PROPOSED COST- CONTAINMENT CHANGES IN HEALTH CARE SERVICES AND COVERAGE

Introduction

In this chapter the focus of the discussion moves from the general to the specific. Physicians were taken through a list of twenty-three cost-containment policy proposals, all of which have the intention of reducing either nonessential utilization, or health care costs, or both.

Some of these policies relate to employer-provided health care plans, some to government policies and programs, and some to both the public and the private sector.

Most of these policies are not entirely new. Indeed, many of them are already being applied, at least in a limited way, by some employers and insurance plans or in parts of the public sector. Almost all of them require sacrifices of some kind by patients or providers. Some involve increased cost-sharing by consumers or reduced freedom to choose health care providers; others involve alternatives to the traditional fee-for-service payment system.

For this reason, the questions in this survey did not ask physicians what policies they would ideally like to have, but rather what they would be willing to accept in the interest of controlling health care costs and spending.

The Findings

Responses to these different proposals vary widely from overwhelming acceptance to massive opposition. One general finding, which is true of the majority of proposals, is the relatively high correlation between the perceived effectiveness of a policy and its acceptability to physicians. Where a policy is perceived to be effective, it is generally acceptable. Where it is not acceptable, it is generally not thought to be effective.

Detailed data from the physician survey are presented in Table 3-1, while Table 3-2 provides comparative data on the same items from the earlier survey.*

• Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more out-of-pocket costs to the American public

Large majorities of physicians, like physician leaders and hospital administrators, believe that policies which would increase cost-sharing by patients would be both effective and acceptable. These policies, namely paying part of the insurance premiums, and increased deductibles and copayments, are also acceptable, albeit by much smaller margins, to the American public.

The administration's proposal to tax the top portion of large health insurance premiums is acceptable to only 41% of the physicians, in contrast with 62% of the physician leaders and 51% of the hospital administrators. Not surprisingly, the majority of the American public oppose this proposal which does not provide a personal incentive for decreased utilization of health care services.

• Proposals aimed at keeping hospitalization to a minimum by offering other treatment options

Large majorities of physicians endorse health insurance plans that discourage unnecessary hospitalization. Almost all physicians think that insurance plans that encourage the care and treatment of the chronically ill at home, and plans that encourage people to have tests and minor surgery done in clinics and doctors' offices, would be both effective and acceptable.

Reactions were less supportive of insurance plans which require prior approval by insurance companies for nonemergency hospitalization. While a majority regard such a policy as effective, most also think that it would not be acceptable.

These views essentially parallel those of physician leaders and hospital administrators. The American public differs from the provider groups only in that a modest majority (57%) consider precertification for nonemergency hospitalization acceptable.

*The Equitable Healthcare Survey: Options for Controlling Costs. Louis Harris and Associates, August 1983.

- **Proposals to place constraints on price or use of health care services and on equipment purchases**

Any proposal that places constraints on prices is likely to be met with opposition from physicians, despite their marginal willingness to acknowledge the potential effectiveness of these proposals in slowing down the escalation in health care spending.

The notion of government price controls on doctors' and hospital fees draws the greatest consensus of negative response. Fully 85% of the physicians consider such controls unacceptable, even though about half of the group concede that they would be effective. Government price controls are also unacceptable to large majorities of physician leaders and hospital administrators. The American public, however, would consider these controls acceptable by a margin of 61-36%. This potential public support for government price controls truly underscores the gravity of the problem of health cost inflation.

Physicians find the notion of diagnosis-related group-based fixed fees a little more palatable than government price controls. However, a significant 61% consider this policy unacceptable, even though 58% acknowledge its effectiveness in controlling costs. Physician leaders are similarly opposed to this policy, while majorities of hospital administrators and the public would find it acceptable.

All three provider groups view the proposals regarding second opinions for nonemergency surgery, discouraging duplication of expensive treatments at nearby hospitals, and utilization reviews as generally effective and acceptable. The last proposal—utilization reviews by third-party payers—is acceptable to physicians and physician leaders by very small margins.

- **Proposed changes in insurance plans that provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures**

Physicians' reactions to these proposals, which essentially outline a variety of alternatives to the traditional fee-for-service system, are generally cool.

Most physicians think that Health Maintenance Organizations (HMO's), where for a monthly fee patients receive all physicals, doctors' visits, and hospitalization, are both ineffective and unacceptable.

Preferred Provider Organizations (PPO's) also tend to be regarded as unacceptable by most physicians, although a modest majority concede that PPO's may be effective in controlling prices. These negative reactions apply to both PPO-type plans which exclude all doctors and hospitals not on authorized lists and those which pay a (smaller) part of the cost of the services of these providers. Again these views are consistent with those of physician leaders and not with those of the public. Hospital administrators find the more liberal of the two proposals acceptable.

Health insurance plans in which a primary care provider selected from a list of doctors provides all basic medical care for a fixed fee and assumes the responsibility for authorizing all additional medical services are believed to be effective by a two-thirds majority of physicians, but considered acceptable by only 52%.

Physicians' attitudes to these alternatives to the fee-for-service system closely parallel those of physician leaders, but deviate significantly from those of hospital administrators and the public. The latter two groups, for the most part, find these alternatives acceptable.

- **Proposals that suggest providing incentives for health maintenance and preventive care**

An overwhelming majority of physicians view insurance plans that offer incentives to people who practice health and safety procedures as both effective and acceptable. A large majority feel similarly about group refunds to employees for expenditures that fall below target.

These views are shared by large majorities of physician leaders, hospital administrators, and the general public.

- **Proposed changes in malpractice and anti-trust laws**

Changes in laws relating to malpractice which would reduce the pressure on doctors to practice defensive medicine are generally thought to be both effective and acceptable as cost-containment measures. Physician leaders and hospital administrators concur with physicians on this issue.

Most (71%) physicians believe that changes in anti-trust laws which would allow third-party payers to join together to negotiate fees with hospitals would be effective in reducing costs, but a somewhat smaller majority (55%) consider this proposal acceptable. Physician leaders are split on this issue, but the proposal is acceptable to hospital administrators by a two-thirds majority.

- **Other proposed policies and changes**

Health care coalitions of businesses and employees are generally regarded as effective and acceptable by most physicians, as well as by most physician leaders and hospital administrators.

While half of the physicians concede that a greater use of nurse practitioners, midwives, and physicians' assistants would be effective in reducing health care spending, a significant minority (43%) are also willing to accept a system that encourages this practice. The majority of physician leaders, however, find this proposal unacceptable, while a modest majority of hospital administrators and the American public consider it acceptable.

Limiting the use of expensive procedures for patients with virtually no hope of recovery — so-called "heroic" medicine — is viewed as an effective cost-containment proposal by 78% of the physicians, but considered acceptable by a much smaller majority (59%). The physicians' view on the acceptability of this proposal parallels that of physician leaders. The opinions of hospital administrators and the American public are evenly split on this issue.

To sum up, it appears that American physicians, as a group, are more willing to accept changes in the health care system than are the heads of state, local, and specialty medical societies. Not surprisingly, the cost-containment proposals that they are least likely to find acceptable are those that would adversely affect their income. However, sizable minorities consider even those proposals acceptable. The only proposal that an overwhelming majority of physicians find unacceptable is government price controls. And yet, slightly over one-third of the physicians consider a DRG-based prospective payment system acceptable.

Table 3-1

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care. For each one, I will ask you two questions:

- Q. Do you think it will be very effective, somewhat effective, not very effective, or not at all effective in *controlling costs or discouraging use* of nonessential services?
- Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

**Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more
out-of-pocket costs to the American public**

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Requiring employees to pay a part of their health insurance premiums				
How effective	25	47	19	8
How acceptable	39	43	11	5
Increasing the deductible—the costs that a patient must pay before the insurance plan starts to cover medical expenses—so that people become more cost-conscious when seeking medical services				
How effective	41	44	10	4
How acceptable	41	34	14	10
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses				
How effective	37	44	14	4
How acceptable	34	37	16	11
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family				
How effective	10	27	30	22
How acceptable	15	26	21	26

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposals that are aimed at keeping hospitalization to a minimum by offering other treatment options

Base: 500	Very	Somewhat	Not Very	Not at All
	%	%	%	%
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes				
How effective	60	33	4	3
How acceptable	66	27	2	4
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals				
How effective	60	32	5	1
How acceptable	66	27	4	2
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization				
How effective	20	40	21	14
How acceptable	14	27	24	33

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposals to place constraints on price or use of health care services and on equipment purchases

Base: 500	Very	Somewhat	Not Very	Not at All
	%	%	%	%
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary				
How effective	17	37	27	19
How acceptable	41	33	10	13
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby				
How effective	32	41	17	9
How acceptable	31	34	17	16
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures				
How effective	14	47	23	13
How acceptable	18	35	19	25
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed				
How effective	15	43	22	15
How acceptable	9	28	25	36
Government price controls of doctors' and hospital fees				
How effective	17	32	18	30
How acceptable	3	10	15	69

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposed changes in insurance plans that provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures

Base: 500	Very	Somewhat	Not Very	Not at All
	%	%	%	%
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient				
How effective	19	49	20	11
How acceptable	15	37	19	28
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list				
How effective	12	50	23	13
How acceptable	11	30	27	31
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services				
How effective	12	27	28	30
How acceptable	13	27	18	40
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive				
How effective	12	40	29	15
How acceptable	8	26	24	39

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposals that suggest providing incentives for health maintenance and preventive care

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Insurance plans that offer incentives to people who practice health and safety procedures—such as nonsmokers, seatbelt users, or those who are not overweight				
How effective	46	37	12	3
How acceptable	80	15	3	2
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target				
How effective	27	50	16	5
How acceptable	49	37	5	6

Proposed changes in malpractice and antitrust laws

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits				
How effective	40	39	8	9
How acceptable	55	23	6	13
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders				
How effective	18	53	14	9
How acceptable	16	39	16	23

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Other policies

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs				
How effective	22	57	11	5
How acceptable	33	46	7	9
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery				
How effective	39	39	12	7
How acceptable	30	29	14	23
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians				
How effective	8	42	29	17
How acceptable	11	32	22	32

Note: Those who are "not sure" or responded "refused/no answer" are not shown on this table.

Table 3-2

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care.

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

**Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more
out-of-pocket costs to the American public**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Requiring employees to pay a part of their health insurance premiums				
Very/somewhat acceptable	82	89	81	65
Not very/not at all acceptable	16	10	18	32
Increasing the deductible—the costs that a patient must pay before the insurance plan starts to cover medical expenses—so that people become more cost-conscious when seeking medical services				
Very/somewhat acceptable	75	89	79	58
Not very/not at all acceptable	24	10	20	39
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses				
Very/somewhat acceptable	71	82	76	52
Not very/not at all acceptable	27	17	22	46
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family				
Very/somewhat acceptable	41	62	51	39
Not very/not at all acceptable	47	36	43	56

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposals that are aimed at keeping hospitalization to a minimum by offering other treatment options

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes				
Very/somewhat acceptable	93	91	91	78
Not very/not at all acceptable	6	7	8	20
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals				
Very/somewhat acceptable	93	99	84	83
Not very/not at all acceptable	6	1	13	16
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization				
Very/somewhat acceptable	41	34	47	57
Not very/not at all acceptable	57	66	51	41

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposals to place constraints on price or use of health care services and on equipment purchases

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary				
Very/somewhat acceptable	74	63	84	88
Not very/not at all acceptable	23	37	15	10
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby				
Very/somewhat acceptable	65	51	73	62
Not very/not at all acceptable	33	47	25	36
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures				
Very/somewhat acceptable	53	52	66	x
Not very/not at all acceptable	44	47	33	x
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed				
Very/somewhat acceptable	37	32	71	76
Not very/not at all acceptable	61	67	27	21
Government price controls of doctors' and hospital fees				
Very/somewhat acceptable	13	7	21	61
Not very/not at all acceptable	85	90	74	36

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposed changes in insurance plans that provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient				
Very/somewhat acceptable	52	48	80	69
Not very/not at all acceptable	47	52	19	29
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list				
Very/somewhat acceptable	41	41	68	61
Not very/not at all acceptable	58	58	32	36
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services				
Very/somewhat acceptable	40	37	66	61
Not very/not at all acceptable	58	61	33	36
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive				
Very/somewhat acceptable	34	31	45	62
Not very/not at all acceptable	63	68	53	34

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposals that suggest providing incentives for health maintenance and preventive care

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Insurance plans that offer incentives to people who practice health and safety procedures—such as nonsmokers, seatbelt users, or those who are not overweight				
Very/somewhat acceptable	95	97	92	80
Not very/not at all acceptable	5	2	7	18
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target				
Very/somewhat acceptable	86	89	88	x
Not very/not at all acceptable	11	10	10	x

Proposed changes in malpractice and antitrust laws

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits				
Very/somewhat acceptable	78	86	77	x
Not very/not at all acceptable	19	12	20	x
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders				
Very/somewhat acceptable	55	47	69	x
Not very/not at all acceptable	39	52	27	x

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Other policies

	Physicians	Physician Leaders¹	Hospital Administrators¹	Public¹
Base	500	100	100	1501
	%	%	%	%
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs				
Very/somewhat acceptable	79	85	87	x
Not very/not at all acceptable	16	15	12	x
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery				
Very/somewhat acceptable	59	59	48	49
Not very/not at all acceptable	37	38	49	46
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians				
Very/somewhat acceptable	43	24	59	63
Not very/not at all acceptable	54	75	40	35

Note: Those who are "not sure" or responded "refused/no answer" are not shown on this table.

x = Item not asked of these respondents

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

There are some differences in the attitudes of physicians from different geographic regions towards cost-containment proposals which have a direct or indirect impact on their income (Table 3-3). These differences are as follows:

- The HMO-type prepaid plan finds lower acceptability in the South and West, as compared to the East and Midwest.
- The regional differences in attitudes toward the use of nurse practitioners, midwives, and physicians' assistants instead of physicians are marginal, being unacceptable to slightly more physicians in the South and West.
- Physicians in the South show a greater consensus regarding the unacceptability of preferred provider plans than do physicians in the other regions.
- A system with fixed diagnosis-related fees applying to all providers is also unacceptable to a larger majority of physicians in the South than in any other region.
- While government price controls are unacceptable to very large majorities in all regions, they are unacceptable to virtually all physicians in the South.

There are minor differences of opinion regarding the above five proposals among physicians who graduated from medical school at different points in time. It is, however, interesting to note that the HMO-type prepaid plan finds greater acceptability among younger physicians than among older physicians. Although this finding is not surprising, it is important to note that among physicians who graduated less than six years ago, a marginal majority (51%) consider the HMO-type plan acceptable.

An interesting difference is evident in the attitudes of younger versus older physicians towards proposals for increased cost-sharing by patients. Older physicians tend to endorse these proposals in larger numbers than younger physicians (Table 3-4).

Table 3-3

**ACCEPTABILITY OF POLICIES WHICH HAVE A DIRECT OR INDIRECT IMPACT
ON PHYSICIANS' INCOMES: BY REGION AND YEARS SINCE GRADUATION**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care.

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

	Total Physicians	Region				Years Since Graduation			
		East	Mid- west	South	West	5 or Less	6-10	11-20	21 or More
Base	500	150	112	128	110	73	120	119	175
	%	%	%	%	%	%	%	%	%
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians									
Very/somewhat acceptable	43	46	46	41	39	44	42	40	45
Not very/not at all acceptable	54	51	51	56	58	54	55	58	53
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list									
Very/somewhat acceptable	41	41	47	31	44	41	42	42	39
Not very/not at all acceptable	58	57	52	66	56	57	59	58	59
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services									
Very/somewhat acceptable	40	46	44	32	35	51	45	39	30
Not very/not at all acceptable	58	52	55	63	63	48	53	58	67
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed									
Very/somewhat acceptable	37	42	38	29	37	34	34	39	38
Not very/not at all acceptable	61	56	61	68	60	63	66	60	58
Government price controls of doctors' and hospital fees									
Very/somewhat acceptable	13	19	12	5	14	15	15	11	11
Not very/not at all acceptable	85	81	87	92	84	82	85	89	88

Table 3-4

**ACCEPTABILITY OF PROPOSED CHANGES IN HEALTH CARE COVERAGE DESIGNED TO
REDUCE NONESSENTIAL UTILIZATION BY SHIFTING MORE OUT-OF-POCKET COST TO
THE AMERICAN PUBLIC: PHYSICIANS BY YEARS SINCE GRADUATION**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care.

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

	Total Physicians	Years Since Graduation			
		5 or Less	6 to 10	11 to 20	21 or More
Base	500	73	12	119	175
	%	%	%	%	%
Requiring employees to pay part of their health insurance premiums					
Very/somewhat acceptable	82	75	79	90	82
Not very/not at all acceptable	16	24	18	8	14
Increasing the deductible— the costs that a patient must pay before the insurance plan starts to cover medical expenses—so that people become more cost-conscious when seeking medical services					
Very/somewhat acceptable	75	72	68	76	81
Not very/not at all acceptable	24	26	31	24	17
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses					
Very/somewhat acceptable	71	64	66	73	78
Not very/not at all acceptable	27	35	33	25	20
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family					
Very/somewhat acceptable	41	46	39	37	43
Not very/not at all acceptable	47	50	52	50	41

In practice, many employers and insurers do not introduce changes to their health care plans one at a time. It is common practice to combine reductions in benefits with some additional benefits in order to make the reductions more acceptable to employees. This is particularly common where changes in health plans involve sizable increases in deductibles, or copayments, or both.

In this survey physicians were asked about five types of changes to health care plans which involve some trade-offs between reduced benefits and additional benefits. Such changes are thought to be fair and reasonable by large majorities of physicians. The types of changes which are thought to be fair and reasonable are:

- Plans which provide better coverage for tests conducted outside hospitals than for those involving overnight hospitalization;
- Plans which require higher deductibles and copayments for the initial cost of health care, but which provide better coverage for the cost of longer-term care;
- Plans which require patients to pay a larger share of the cost of using hospital emergency rooms, but which provide better coverage for treatment at doctors' offices;
- Plans which require patients to pay a larger share of the cost of overnight hospitalization, but which provide better coverage for ambulatory surgery; and
- Plans which require higher deductibles and copayments, but which include additional dental and vision benefits. It should be noted, however, that about one-third of the physicians do not consider this trade-off fair and reasonable.

Physicians' views on these trade-offs are very similar to those of physician leaders and hospital administrators. One noteworthy finding is that while large majorities of all three groups find the trade-off involving better coverage for longer-term treatment fair, the opinion of the physician leaders is almost unanimous on this point. With the exception of the trade-off involving the addition of dental and vision benefits to a health care plan, all three provider groups consider the trade-offs to be fair by larger majorities than does the American public. The public considers this last trade-off fair and reasonable by a slightly larger margin than do the provider groups (Table 3-5).

Table 3-5

**TRADE-OFFS IN HEALTH CARE COVERAGE CONSIDERED FAIR AND REASONABLE:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. I will read you some proposed changes in health insurance plans that involve a trade-off between better coverage for some health care services and higher cost to the patient for others. For each one, please tell me if you think the trade-off is fair and reasonable.

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Providing better coverage for tests conducted without hospitalization than for tests involving overnight hospitalization				
Yes, is fair and reasonable	85	87	77	67
No, isn't fair and reasonable	13	12	21	28
Requiring a patient to pay a larger share of the cost of care obtained at hospital emergency rooms, but with better coverage for treatment at the doctor's office				
Yes, is fair and reasonable	82	83	72	52
No, isn't fair and reasonable	13	14	26	44
Requiring higher deductibles and copayments for the initial cost of health care, but with better coverage for the cost of longer-term treatment				
Yes, is fair and reasonable	81	96	84	61
No, isn't fair and reasonable	15	2	14	34
Requiring patients to pay a larger share of the cost of overnight hospital stays, but providing better coverage for surgery that does not involve hospitalization				
Yes, is fair and reasonable	71	80	76	51
No, isn't fair and reasonable	23	17	23	44
Requiring higher deductibles and copayments, but adding dental and vision benefits in the health care plan				
Yes, is fair and reasonable	57	55	60	65
No, isn't fair and reasonable	34	43	36	30

Note: Those "not sure" are not shown on this table.

¹Source: The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983.

CHAPTER 4: OPINIONS ON COST-SHIFTING AND HEALTH CARE COVERAGE FOR THE UNEMPLOYED

There is overwhelming disapproval among physicians, as well as the other provider groups, of the concept of cost-shifting. The American public also disapproves of doctors and hospitals being paid less for Medicare and Medicaid patients if it results in higher fees for everyone else. However, a noteworthy minority (22%,) approves of cost-shifting (Table 4-1).

Table 4-1

ATTITUDES TOWARD MEDICARE AND MEDICAID COST-SHIFTING: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. Current and proposed government regulations limit the amount the government will pay hospitals and doctors for Medicare and Medicaid patients. Some doctors and hospitals, therefore, are paid less for Medicare and Medicaid patients, and charge higher fees for patients who pay their own bills or are covered by private insurance.

Do you approve or not approve of the government paying lower fees for Medicare and Medicaid patients if it results in higher fees for everyone else?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Approve	9	5	7	22
Do not approve	87	95	87	74
Not sure/no opinion/no answer	4	—	5	4

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

The attitudes of physicians to policies designed to provide the unemployed better access to health care vary widely from policy to policy. The two policies favored by the majority of physicians (62% and 69%, respectively) are: requiring employers, by law, to maintain health insurance benefits for six months past termination of employment; and encouraging each state to provide health care coverage for its unemployed workers.

Policies to finance coverage for the unemployed not favored by the majority of physicians are: new taxes on individuals' employer-paid health insurance premiums; establishment of a federal program similar to Medicare; and new taxes on third-party payers (Table 4-2).

Table 4-2

PHYSICIANS' ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED

Q. One group that is largely not covered by health insurance is the unemployed. Several proposals have been made to ensure that this group gets some type of health care coverage. For each proposal I read to you, please tell me whether or not you favor it.

	Total Physicians
Base	500
	%
Encouraging but not requiring each state to pay for health care coverage for unemployed workers	
Favor	69
Do not favor	28
Not sure/no opinion	3
Requiring employers, by law, to maintain health insurance benefits for laid-off workers for six months and contribute to a pool of funds to provide another twelve months of coverage	
Favor	62
Do not favor	34
Not sure/no opinion	3
Financing health care coverage for the unemployed by establishing a federal government program similar to the Medicare program	
Favor	43
Do not favor	54
Not sure/no opinion	3
Establishing a tax on third-party payers to finance extension of benefits for the unemployed	
Favor	34
Do not favor	62
Not sure/no opinion	4
Financing health care coverage for the unemployed from new taxes on individuals' employer-paid health insurance premiums that exceed a set amount	
Favor	31
Do not favor	65
Not sure/no opinion	4

Overall, physicians favor providing health care coverage for unemployed workers and their families, even if it means a direct or indirect increase in the cost of health care to other people. It is not surprising that while a majority in the provider groups favor health care coverage for the unemployed despite cost to others, a modest majority of the American public do not (Table 4-3).

Table 4-3

**ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED
DESPITE COST TO OTHERS: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Do you favor providing health care coverage for unemployed workers and their families *even if* it means that the cost to other people will increase directly or indirectly through higher medical or insurance bills or increased taxes?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Yes, favor	61	67	58	43
No, do not favor	33	28	38	53
Not sure/no opinion	6	4	4	3

¹Source: *The Equitable Healthcare Survey: Options for Controlling Costs*, Louis Harris and Associates, August 1983

APPENDIX A: SURVEY METHOD

The methodology used in this survey parallels that for the health care cost-containment survey conducted in 1983. The reader is referred to the report entitled **The Equitable Healthcare Survey: Options for Controlling Costs** for details on the research procedures used in the earlier study.

Procedures used in this study are detailed below.

The Sample

A total of 500 interviews were conducted with a national cross section of practicing physicians. A list of 2,500 names was obtained from the American Medical Association and the sample was drawn systematically (one name from a cluster of five names) with regional controls.

Interviewing

All interviews were conducted by telephone from the New York offices of the National Center for Telephone Research, the division of Louis Harris and Associates which conducts all the firm's telephone interviews. All interviews were subject to careful monitoring and supervision. Interviews were conducted from January 9, 1984 through February 14, 1984.

Data Processing

The editing, coding, and data processing of all questionnaires were conducted by Louis Harris and Associates. Codes developed for responses to open end questions from the earlier survey were used in this study to ensure comparability of the data.

Weighting of the Data

The data reported on the sample of 500 physicians are not weighted. Comparison data on physician leaders and hospital administrators from the earlier study are also unweighted. The data from the public sample were weighted to be representative of the population of U.S. households. The weights were based on the 1980 census counts for age, race, sex, and income.

APPENDIX B: PROFILE OF THE PHYSICIAN SAMPLE

	Unweighted Percentage in Sample
Base	500
	%
AMA Membership	
Members	53
Nonmembers	46
Years Since Graduation	
Five years or less	15
Six to ten years	24
Eleven to twenty years	24
Twenty-one or more years	35
Type of Employment	
Self-employed (only)	66
Salaried employee (only)	30
Both self-employed and salaried	4
Primary Specialty	
Allergy	1
Anesthesiology	5
Cardiovascular Disease/Cardiology	3
Dermatology	1
Diagnostic Roentgenology	*
Emergency Medicine	3
Endocrinology	*
Family Practice	13
Gastroenterology	1
General Practice	4
Internal Medicine (General)	12
Nephrology	*
Neurology	1
Obstetrics and Gynecology	10
Oncology	1
Ophthalmology	3
Otorhinolaryngology/ENT	1
Pathology	3
Pediatrics	7
Psychiatry	9
Pulmonary Diseases	*
Radiology/Therapeutic Radiology	8
Cardiovascular Surgery	1
General Surgery	5
Head and Neck Surgery	*
Neurological Surgery	1
Orthopedic Surgery	3
Plastic Surgery	*
Thoracic Surgery	*
Urological Surgery/Urology	2
Other	3

*Less than 0.5%

The Equitable Life Assurance Society of the United States
1285 Ave. of the Americas, New York, N.Y. 10019